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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Feb/02/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Continued outpatient post-operative physical therapy (PT) to the right ankle and left knee three (3) times per week over four (4) weeks, consisting of therapeutic exercises, manual therapy, hot/cold packs, therapeutic activities, gait training and electric stimulation not to exceed four (4) units per session

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D., Board Certified Orthopedic Surgery

REVIEW OUTCOME: Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for <u>each</u> health care service in dispute. It is the opinion of the reviewer that the request for Continued outpatient post-operative physical therapy (PT) to the right ankle and left knee three (3) times per week over four (4) weeks, consisting of therapeutic exercises, manual therapy, hot/cold packs, therapeutic activities, gait training and electric stimulation not to exceed four (4) units per session is not recommended as medically necessary

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female whose date of injury is xx/xx/xxxx. On this date she was involved in an auto-pedestrian accident. She suffered a fracture of the right ankle along with extensive soft tissue injuries involving the left lower extremity from the hip to the foot. The patient underwent right ankle ORIF in July 2014. Plan of care dated 12/15/14 indicates that the patient has completed 48 physical therapy visits to date. The patient reports that she has been walking at home during the day. She has pain in both ankles. Pain level is 3/10 both pre- and post-treatment. On physical examination she had full active knee extension. Gait is still very slow. Letter of medical necessity dated 12/23/14 indicates that she has been cooperative with all rehabilitative efforts, but continues to have significant arthrofibrosis issues involving the left knee and ankle area. Follow up note dated 01/08/15 indicates that the patient continues to complain of right ankle pain. Current medications are Phenergan and meloxicam. On physical examination her ankle demonstrates 5/5 strength with dorsiflexion, plantar flexion, inversion and eversion. She has ankle dorsiflexion 10 degrees and plantar flexion 25 degrees. She has good eversion and some limitation on inversion. Assessment is right medial malleolus fracture which is healed. The note states that as far as is concerned, she has reached maximum medical improvement. She is still sitting in a wheelchair despite many recommendations that she needs to be up and walking. She has no restrictions at this point, and he notes that he has nothing further to offer her.

Initial request for continued outpatient postoperative physical therapy to the right ankle and left knee three times per week over 4 weeks, consisting of therapeutic exercises, manual therapy, hot and cold packs, therapeutic activities, gait training and electric stimulation not to exceed four units per session was non-certified on 12/10/14 noting that the claimant has had at least 48 physical therapy sessions authorized since her ORIF. Per ODG post-op physical therapy guidelines, up to 21 physical therapy sessions are indicated. Therefore, the medical necessity for additional physical therapy is not supported. This claimant should be able to transition to a home exercise program based on the physical therapy she has had. There are no extenuating circumstances to support additional physical therapy at this juncture. The denial was upheld on appeal dated 01/07/15 noting that there are no current measurements of motion. There is no reason given for exceeding the guidelines as she has received quite a number of visits already in excess of the guidelines. She is basically 6 months from her injury and beyond the time frame for acute PT.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient underwent open reduction internal fixation of the right ankle in July 2014 and has completed at least 48 postoperative physical therapy visits to date. The Official Disability Guidelines support up to 21 sessions of physical therapy for the patient's diagnoses, and there is no clear rationale provided to support exceeding these recommendations. There are no exceptional factors of delayed recovery documented. Per note dated 01/08/15, she has reached maximum medical improvement. She is still sitting in a wheelchair despite many recommendations that she needs to be up and walking. She has no restrictions at this point, and he notes that he has nothing further to offer her. There appears to be a non-compliance issue as the patient has not adhered to recommendations that she walk. The patient has completed sufficient formal therapy and should be capable of continuing to improve strength and range of motion with an independent, self-directed home exercise program. As such, it is the opinion of the reviewer that the request for Continued outpatient post-operative physical therapy (PT) to the right ankle and left knee three (3) times per week over four (4) weeks, consisting of therapeutic exercises, manual therapy, hot/cold packs, therapeutic activities, gait training and electric stimulation not to exceed four (4) units per session is not recommended as medically necessary and the prior denials are upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

[ ] ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

[ ] AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

[ ] DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

[ ] EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

[ ] INTERQUAL CRITERIA

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

[ ] PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

[ ] TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

[ ] TEXAS TACADA GUIDELINES

[ ] TMF SCREENING CRITERIA MANUAL

[ ] PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)